Beyond Evidence: The Moral Case for International Mental Health

The global burden of disease attributable to mental, neurological, and substance use disorders is expected to rise from 12.3% in 2000 to 14.7% in 2020 (1). This rise will be particularly sharp in developing countries. Research has documented the socioeconomic determinants of many disorders, the profound impact on the lives of those affected and their families, and the lack of appropriate care in developing countries. The enormous gap between mental health needs and the services in developing countries has been documented in international reports, culminating in the *World Health Report 2001* (2). This evidence has increased the profile of international mental health, but action still remains limited. With every new public health challenge, mental health is once more relegated to the background. We argue that moral arguments are just as important as evidence to make the case for mental health intervention. At the center of these moral arguments is the need to reclaim the place of mental health at the heart of international public health. We consider some moral arguments for international mental health and an example from another area of public health in which the moral case was an important enough argument for making policy changes and implementing interventions.

"The overwhelming majority of the 400 million persons with mental disorders globally are not being provided with…basic mental health care."

No health without mental health. Mental health is closely linked with virtually all global public health priorities. Alcohol abuse is a major risk factor for unsafe sexual behavior, and persons with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) have high rates of cognitive impairment and depression (3). Stress and anxiety predispose to myocardial infarction, and the latter leads to higher rates of depression (4). Maternal depression is associated with childhood failure to thrive in developing countries; failure to thrive can lead to developmental delays and psychiatric problems in later life (5). Alcohol abuse and personality disorder frequently precede violence and depression, and suicide frequently follows (6). The moral case is that there is no health without mental health. Mental health interventions must be tied to any program dealing with physical health.

Mental disorders are treatable in developing countries. Clinical trials have demonstrated the efficacy and cost-effectiveness of locally feasible treatments for depression, schizophrenia, and substance abuse in developing countries (7–9). All these studies share one finding: mental illnesses can be treated with cheap and technically simple treatments. The work of committed grassroots organizations demonstrates how this sector has been implementing mental health interventions at low cost (10). The moral case is that it is unethical to deny effective, acceptable, and affordable treatment to millions of persons suffering from treatable disorders. Community and primary care treatment programs must be generously supported by donor agencies.

Paying for new psychiatric drugs. Many developing countries were able to produce generic versions of drugs because of a less rigid enforcement of international patent regulation. Since a substantial proportion of drug costs are met out of pocket, this allowed newer medications to be accessible to low-income groups. This situation was changed with the enforcement of the Trade Related Intellectual Property Rights international agreement in 2005. The agreement dictates that any drug patented after 2005

will not be available except at the price set by the company that holds the patent (11). Governments can exempt diseases that are life-threatening or national emergencies from the Trade Related Intellectual Property Rights charter. Mental illness does not figure as an exemption category. The moral case is that the mentally ill have a right to access affordable, evidence-based treatments. Mental illnesses must be excluded from the Trade Related Intellectual Property Rights charter.

Reversing the brain drain. The most startling finding of the World Health Organization Atlas report is the impossibly enormous inequity in the distribution of mental health manpower in the world (12). A tiny fraction of this manpower resides in regions of the world where over 90% of the global population lives. Despite this glaring inequity, the demand for specialists in richer countries only grows, worsening the brain-drain of mental health resources from developing countries. The vast majority of these professionals have been trained in publically funded medical schools. The moral case is that the people of poor countries should not be paying for the mental health care of those living in the richer world. There needs to be an acknowledgment that institutions in developed countries have an ethical obligation to facilitate the return of professionals and to foster long-term partnerships with developing countries to build mental health capacity.

Violating human rights. There is a history of human rights violations of persons with mental disorders across the world, but today the most disturbing examples are found in developing countries. The Asia edition of the newsmagazine *Time* from Nov. 24, 2003, detailed contemporary accounts of the lives of people living in mental hospitals in Southeast Asia. Patients, typically long-term residents, lose contact with their families, rarely see a mental health professional, are treated with old drugs with severe side effects, are offered few rehabilitative therapies, are kept in crowded wards with no hint of dignity, and are given unmodified electroconvulsive therapy. The Erwadi tragedy in India in 2001, where over 20 persons with mental illness were burned to death when a fire swept the healing temple where they were chained to their beds, reminds us of human rights abuses that take place under the guise of traditional medicine. The stigma of mental illness is so great that the mentally ill are unable to gain employment, finish schooling, marry, live independently, or have their care paid for by insurance companies. The moral case is that the rights of the mentally ill continue to be denied by many sectors in society. We need to provide technical and financial support for hospitals to reform, to enable the development of community care programs, to raise mental health literacy in the community and among health workers, and to ensure that basic rights are monitored and enforced.

Social change and mental health. Most developing countries are witnessing social and economic changes at a pace that is unparalleled in history. Not everyone has benefited from these changes. Economic change is coupled with migration from rural to urban areas, disrupting social networks and household economies. The decrease of trade barriers reducing costs of consumer items is coupled with cheap imports, leading to unemployment of small-scale entrepreneurs and farmers. The reduction in state budgets is being most acutely felt in social spending, where they are most needed. The rising tide of suicides and premature mortality in some countries, as vividly seen in the alcohol-related deaths of men in Eastern Europe and the suicides of farmers in India, indigenous peoples in South America, and young women in rural areas in China, can be at least in part linked to rapid economic and social change (13, 14). The moral case is that mental health problems are not a luxury item on the health agenda of the poor and marginalized. Mental disorders must be included in programs directed to promoting the health of the poor and mental health indicators used to evaluate the larger social impact of globalization.

The overwhelming majority of the 400 million persons with mental disorders globally are not being provided with even the basic mental health care that we know they should

and can receive. Research evidence will not reduce this inequity. To make a change, the moral case must be heard.

Consider the moral argument that persons with HIV/AIDS in developing countries had the right to access antiretroviral drugs, that the state had to provide them for free, that drug companies had to reduce their prices, that apparently complex treatment regimens could be provided by primary health care providers with appropriate training and support, that discrimination against people with HIV/AIDS had to be combated vigorously, and that knowledge about HIV/AIDS was the most powerful tool to combat stigma. These arguments were moral and human rights based. The arguments were made by a coalition of academics, community leaders, people living with HIV/AIDS, rock stars, and public heroes. The case they made was so compelling that governments from India to South Africa changed their policy on antiretroviral drugs. Drug companies agreed to reduce prices of medicines. The World Health Organization decided on 3×5 as their lead initiative, aiming to get antiretroviral drugs to 3 million people by 2005.

We believe that the time is ripe for such a global mental health advocacy initiative that makes the moral case for the mentally ill. It is unacceptable to continue business as usual. Borrowing from the lessons of our colleagues in other areas of public health, such an initiative could take the form of a Global Alliance for Mental Health, under the umbrella of the World Health Organization, in which mental health professionals work alongside patients, families, and public health groups. The practical design of policies, programs, and interventions is most likely to be effective when articulated with a moral orientation toward sufferers of mental illnesses. The Alliance's primary goal would be to spearhead a movement to increase access to evidence-based care, perhaps a 5×10 program to get 5 million untreated patients into treatment and rehabilitation programs by 2010. Equally important goals would be to combat stigma through concerted campaigns directed at various sectors of society and to strengthen the capacity of health systems to care for the mentally ill. A key task would be to mobilize the massive resources needed to support mental health program development in poor countries.

Mental health professionals in rich countries have an important role to play. They can be advocates to their own health systems to ensure that the moral case is heard and appropriate actions supported. As individuals, they can commit their time to activities that tackle some of the issues on the international mental health agenda. We believe that our ultimate professional goal as mental health professionals in a globalized world is to secure a reasonable opportunity for people with mental disorders to achieve better health outcomes. We already have the evidence we need to make the case for international mental health; it is the moral argument that we now need to make.

References

1. Murray CJL, Lopez AD: Alternative projections of mortality and disability by cause 1990–2020: global burden of disease study. Lancet 1997; 349:1498–1504
2. World Health Organization: The World Health Report 2001: Mental Health: New Understanding, New Hope. Geneva, WHO, 2001
3. Catalan J (ed): Mental Health and HIV Infection. Psychological and Psychiatric Aspects. London, Taylor & Francis, 1999
4. Penninx BWJH, Beekman AT, Honig A, Deeg DJH, Schoevers RA, van Eijk JTM, van Tilburg W: Depression and cardiac mortality: results from a community-based longitudinal study. Arch Gen Psychiatry 2001; 58:227
5. Patel V, Rahman A, Jacob KS, Hughes M: Effect of maternal mental health on infant growth in low income countries: new evidence from South Asia. BMJ 2004; 328:820–823
6. World Health Organization: World Report on Violence and Health: Summary. Geneva, WHO, 2002
7. Chatterjee S, Patel V, Chatterjee A, Weiss H: Evaluation of a community based rehabilitation model for chronic schizophrenia in a rural region of India. Br J Psychiatry 2003; 182:57–62
8. Patel V, Araya R, Bolton P: Treating depression in developing countries. Trop Med Int Health 2004; 9:539–541
9. Wu Z, Detels R, Zhang J, Li V, Li J: Community-based trial to prevent drug use amongst youth in Yunnan, China. Am J Public Health 2002; 92:1952–1957
10. Patel V, Thara R: Meeting Mental Health Needs in Developing Countries: NGO Innovations in India. New Delhi, Sage Publications, 2003

11. Patel V, Andrade C: Pharmacological treatment of severe psychiatric disorders in the developing world: lessons from India. CNS Drugs 2003; 17:1071–1080
12. World Health Organization: Atlas Country Profiles of Mental Health Resources. Geneva, WHO, 2001
13. Sundar M: Suicide in farmers in India. Br J Psychiatry 1999; 175:585–586
14. Phillips MR, Liu H, Zhang Y: Suicide and social change in China. Cult Med Psychiatry 1999; 23:25–50

VIKRAM PATEL, PH.D.
BENEDETTO SARACENO, M.D.
ARTHUR KLEINMAN, M.D.

Address correspondence and reprint requests to Dr. Patel, Sangath Centre, Alto-Porvorim, Goa India 403521; vikram.patel@lshtm.ac.uk (e-mail).

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May:	Hallucinations in Children and Adolescents: Considerations in the Emergency Setting
June:	The Importance of Routine for Preventing Recurrence in Bipolar Disorder
July:	Psychotic and Manic-like Symptoms During Stimulant Treatment of Attention Deficit Hyperactivity Disorder

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